STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395549	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SHERWOOD OAKS STATE LICENSE NUMBER: **197002**	**100 NORMAN DRIVE** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey and Civil Rights Compliance survey completed on June 2, 2023, it was determined that Sherwood Oaks, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0000		
F 0636 SS=D		F 0636		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0636 SS=D	Continued from page 1 483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	1. The MDS for R15 has been corrected and resubmitted. 2. Section F 0300 of the MDS completed over the last 6 months have been reviewed and corrected and resubmitted as indicated. 3. RNAC Employee E1 has been reeducated by the NHA/designee on the need to complete all sections of the MDS including the appropriate use of "dashes". 4. The NHA or designee will audit completion of section 0300 of the MDS weekly for one month and then monthly thereafter or until substantial compliance is achieved. 5. Results will be reviewed at the Quarterly QA Meeting.	Completion Date: **07/06/2023** Status: **APPROVED** Date: **06/20/2023**

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F 0636 SS=D	Continued from page 2 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 0636		

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F 0636 SS=D	Continued from page 3 Based on review of facility documentation, clinical record and staff interview it was determined that the facility failed to submit a complete a MDS for one of six residents (Resident R15). Findings include: Review of facility documentation CMS's RAI Version 3.0 Manual (Resident Assessment Instructions) indicated the following: "Use a check mark for boxes where the instructions state to "check all that apply"". Review of Resident R15 clinical record indicated resident was admitted on 3/1/23, with diagnosis of hypertension (abnormally high blood pressure), and hyperthyroidism (overactivity of thyroid gland resulting in a rapid heartbeat increased rate of metabolism . Which remained current as of the MDS (minimum data set a periodic assessment of resident needs) dated 3/27/23. Review of Resident R15 MDS dated 3/27/23,	F 0636		

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F 0636 SS=D	Continued from page 4 Section F0300 Customary Routine and Activities indicated the following: Section F0300 had dashes in all sections and failed to address any of the questions asked. During an interview on 6/2/23, RNAC (Registered Nurse Assessment Coordinator) Employee E1 confirmed that section F0300 Preferences for Customary Routine and Activities with two sections for daily preferences and activity preferences was incomplete with "dashes" in both boxes. Resident R15 preferences were not indicated in either section nor in the staff or family section for preferences. During an interview on 6/2/23, at 10:39 a.m. . RNAC Employee E1 confirmed that Section F0300 had dashes and that the section was not completed nor were the questions asked or the information gathered prior to the submission of the MDS. 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0636		

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F 0636 SS=D	Continued from page 5 28 Pa. Code 211.5(f) Clinical records.	F 0636		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's	F 0656	1. The careplan for R3 and R15 has been updated to include interventions including wandering and dementia. 2. All resident care plans will be evaluated for the need to add interventions related to dementia and wandering as indicated. 3. All RNs and LPNs will be educated by the Director of Nursing or designee regarding the need to address wandering and dementia and patient centered care interventions to promote safety and to meet the needs of the resident. 4. The Director of Nursing/designee will audit careplans weekly for one month or until substantial compliance is achieved to ensure residents with dementia and wandering is addressed on the comprehensive plan of care. 5. Results will be reviewed at the Quarterly QA Meeting.	Completion Date: **07/06/2023** Status: **APPROVED** Date: **06/20/2023**

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F 0656 SS=D	Continued from page 6 representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 7 Based on review of facility policies, clinical records, and staff interview, it was determined that the facility failed to develop and implement comprehensive care plans to meet resident care needs for two of six residents (Residents R3 and R15). Findings include Review of the facility policy "Care Plan and Interdisciplinary Care Conferences" last reviewed on 4/4/23, with a previous review date of 4/7/22, indicated that an individualized, interdisciplinary care plan is initiated within 24 hours. The care plan is a working tool that is reviewed and revised and is to reflect response to care and changing needs, goals and wishes of each resident and family's overall goals of care. Review of the clinical record indicated that Resident R3 was re-admitted to the facility on 2/1/21, with diagnoses which included Diabetes, heart failure, dementia, insomnia, delusional disorder. A MDS(Minimum Data Set- a periodic assessment of	F 0656		

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F 0656 SS=D	Continued from page 8 resident care needs) dated 4/13/23, indicated the diagnoses remained current. Review of Resident R3's identified as the current plan of care did not include a plan of care for the diagnosis of dementia or interventions related to the diagnosis. Review of the clinical record indicated that Resident R15 was admitted to the facility on 3/1/23, with diagnoses which included back pain, behaviors, wandering and falls . An MDS dated 3/7/23, indicated the diagnoses remained current. The MDS Section P0200 indicated Resident R15 wore an alarm/elopment bracelet daily. Section E0900 indicated Resident R15 wanders 4-6 days, but not daily, and Section E 1000 indicated Resident R15 was at risk for wandering/elopment. Review of the identified as the current plan of care for Resident R15 did not include wandering and interventions for this diagnosis.	F 0656		

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F 0656 SS=D	Continued from page 9 During an interview on 6/2/23, at 9:55 a.m., the Director of Nursing confirmed that the facility failed to develop and implement comprehensive care plan for Resident R3 to include dementia and comprehensive plan of care for wandering for Resident R15. 28 Pa. Code: 211.11(a)(b)(c)(d) Resident care plan.	F 0656		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 10 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. Expired IV bags, culture bottles, and culture swabs were disposed of on 5-31-23. 2. Following the findings the medication rooms were audited for expire supplies. None were found. 3. DON/designee educated RNs and LPNs on the need to audit and dispose of outdated IV supplies in med room. 4. DON/designee will audit med rooms three times a week for 2 weeks and weekly there after until substantial compliance is achieve. 5. Results of the audits will be reported at the quarterly QA meeting.	Completion Date: **07/06/2023** Status: **APPROVED** Date: **06/20/2023**

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F 0761 SS=D	Continued from page 11 Based on review of facility policy, observation and staff interview, it was determined that the facility failed to make certain that outdated biologicals were discarded in one of two medication rooms (Lake Hall medication room). Findings include: Review of the facility policy " Medication and Biological Storage" last reviewed on 4/4/23, indicated that all medications and biologicals are stored and maintained under strict conditions according to accepted standards. All drugs and biologicals will be checked to ensure date prior to use. During an observation of the Lake Hall medication room on 5/31/23, from 9:50 a.m. through 10:10 a.m., the following was identified: [illegible] tubing [illegible] 28 Pa. Code: 211.9(a)(1)(2)(g)(h)(k) Pharmacy services.	F 0761		

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F 0761 SS=D	Continued from page 12	F 0761		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 13 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Resident R7 was assessed after the findings were reported to ensure R7 was not negatively impacted by the failure to remove the belongings on the tray table and cleaning the table table before and after dressing change. 2. Employee E3 was verbally reeducated at the time of the findings by the DON. All RNs and LPNs working the day of the findings were verbally educated and reminding to remove belongings off the tray table and wiping the tray table off before and after a dressing change. 3. The RNs and LPNs will be educated by the Director of Nursing/designee on dressing change practices to prevent cross contamination, specifically the need to remove belongings from the tray table and wiping the tray table before and after a dressing change. 4. The Director of Nursing or designee will observe three staff weekly for the prevention of cross contamination practices and ensuring staff prepare a clean work	Completion Date: **07/06/2023** Status: **APPROVED** Date: **06/21/2023**

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F 0880 SS=D	Continued from page 14 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	space by removing belongings and cleaning the tray table before and after dressing change is completed. Audit will be conducted weekly for 4 weeks then monthly thereafter or until substantial compliance is achieved. 5. Results will be reviewed at the quarterly QA meeting.	

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SHERWOOD OAKS STATE LICENSE NUMBER: **197002**	**100 NORMAN DRIVE** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 15	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395549	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SHERWOOD OAKS STATE LICENSE NUMBER: **197002**	**100 NORMAN DRIVE CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 16 Based on review of facility policies, observation and staff interview, it was determined that the facility failed to prevent the potential for cross contamination during a dressing change for one of four residents (Resident R7). Findings include: Review of the facility policy "Wound Dressing Change" last reviewed on 4/4/23, indicated all wound care will be performed using a clean technique unless otherwise ordered. Adherence to all standard precautions with all wound dressing changes as indicated. Individual resident supplies may be placed on the over-the-bed table after it has been disinfected and dried using an approved cleaning agent and protective barrier applied. During an observation of the pressure wound dressing [illegible] 28 Pa. Code 201.18(a) Management. [illegible] Resident 28 Pa. Code: 201.20(c) Staff development. 28 Pa. Code: 211.10(d) Resident care policies.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395549	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SHERWOOD OAKS STATE LICENSE NUMBER: 197002	100 NORMAN DRIVE CRANBERRY TOWNSHIP, PA 16066

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F 0880 SS=D	Continued from page 17 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0880		

Certified End Page

SHERWOOD OAKS

STATE LICENSE NUMBER: 197002

SURVEY EXIT DATE: 06/02/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY